"Suicide prevention … I hate that word." Women's experiences of carceral logics whilst supporting loved ones with suicidal distress in rural Australia

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ABSTRACT

INTRODUCTION: Modern neoliberal states discipline subjects through diffuse operations of state power by making individuals both the object of and subject of disciplinary gaze. Constructions of activities like caring, which are overwhelmingly performed by women, are devalued and marginalised.

METHODS: Semi-structured interviews were conducted with carers and workers and volunteers in the welfare and community sector from a rural part of Eastern Australia.

FINDINGS: Women's experiences of the mainstream mental health system are characterised by carceral logics which limit women's choice and their relationships with their loved ones, yet some women resist through enacting a form of relational feminist justice.

IMPLICATIONS FOR PRACTICE: This study contributes to broader literature on women's embodied experiences of legislation and critical mental health scholarship on the harms of coercion in the mental health system in many modern neoliberal states. I encourage social workers practising in neoliberal settings to critically reflect on the impact of carceral logics on women who support loved ones with suicidal distress, and I discuss ways social work practice can promote social justice through centring mutuality in relationships.

Keywords: Carceral logics, feminist research, critical mental health, suicide, suicide prevention

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This article examines how carceral logics are enacted on women who support loved ones engaging with mainstream mental health services. It presents unexpected findings from a broader research project examining experiences of help-seeking for suicidal distress in rural and remote New South Wales (NSW), Australia. Specifically, findings from carers and workers/volunteers in the community that emerged during analysis. This paper will present a critical feminist analysis exploring the way the NSW Mental Health Act 2007 and the outflowing carceral logics limited the opportunities for some women. Although this research focused specifically on rural and remote NSW, it is relevant to social workers practising in other largely neoliberal settings, many of which also have mental health legislation containing grounds for involuntary treatment.

Firstly, a note on language. Feminists have critiqued the term *woman* as denoting

potentially hegemonic ideals that invisibilise different experiences of race, gender and sexuality (Lloyd, 2005). Throughout this article I will use the terms *woman* and *women* as these are terms the participants used for themselves in this context; however, this use is with the acknowledgement that this does not mean it is language preferred by all scholars and activists.

Literature

There are approximately 50,000 people caring for a loved one experiencing mental and emotional distress in NSW (Australian Bureau of Statistics, 2019). Of those, the majority are women. Much of the current research literature on experiences of caring for people in suicidal distress examines impacts on the family. This includes the emotional, relational, financial and time burdens of providing support (Grant et al., 2015; C. McLaughlin et al., 2014, 2016). Other studies highlight service deficits, such as barriers to care (Olasoji et al., 2017), lack of collaborative care (including communication issues), limited supports and education for carers (Berzins et al., 2020; Grant et al., 2015; C. McLaughlin et al., 2016). Others position carers as potential threats which may exacerbate a person's suicidal experience (Edwards et al., 2021; Grant et al., 2015). Overall, this literature lacks a critical lens. It fails to attend to the broader issues of psychiatric power and gender, a concerning absence given the over-representation of women within this group.

Recent feminist scholarship has argued that neoliberal mechanisms within the state have co-opted feminist social issues with carceral logic (Gruber, 2020). Carceral logics describe a particular way in which power operates focusing on imprisonment and punishment for socially undesirable behaviour (Gruber, 2020). Critical mental health and feminist scholars have argued that modern neoliberal nation states rely on carceral measures to exert power on the minds and emotions of state subjects (Rose & Lentzos, 2017; Rose & Miller, 2013; Tseris, 2017).

A significant body of research exists from a lived experience of distress on the harms of involuntary treatment and coercion under mental health legislation. This includes iatrogenic harms, trauma from medical and physical restraint, removal of choice, and further exposure to gender based violence (Jones et al., 2021; P. McLaughlin et al., 2016; Seed et al., 2016; Tseris et al., 2022). Women experience psychiatric power in gendered ways. This may include re-experiencing gendered violence, pathologising experiences of gendered oppression as "trauma" as well as the accompanying emotional responses (Rees et al., 2011; Tseris et al., 2022). This functions to de-politicise gendered experiences through disconnection from broader social processes.

The concept of "care" is troubled in feminist scholarship. Some feminist scholars contrast masculinist emphasis on independence and autonomy with interdependence, which is defined as acts of caregiving and receiving across the life course (Tronto, 2020; West & Bowman, 2019). Care and caring in this sense are the foundation of moral reasoning, rather than a state of burdensomeness as often construed through masculine logics (Tronto, 2020).

Yet disability advocates have argued care can be coercive. Care typically involves high degrees of surveillance over disabled people as well as regulation of disabled people's bodies (Hughes et al., 2005). Despite the many changes which have occurred in the mental health system recently (for example, de-institutionalisation, and the "recovery" approach), the coercive powers of psychiatry and its associated professions, including social work, continues (Kent et al., 2022). This has often come under the guise of "care", however, it has resulted in forced engagement with services, involuntary use of medication, and for some, seclusion and physical restraint (Cohen, 1994).

Critical scholars in Australia and the UK have argued that *carers* are discursively constructed. The notion of an informal carer

did not exist prior to deinstitutionalisation of the mental health system in the 1980s and 1990s (Heaton, 1999; Henderson, 2005). As modern neoliberal democracies moved toward defunding institutional settings for treating "mental illness", unpaid carers became central to the functioning of the mainstream mental health system (Henderson, 2005). Heaton (1999) argued that, in the modern neoliberal state, carers have been incorporated, both as operators of and objects in a Foucauldian disciplinary gaze of minds, bodies and emotions. Carers are thus made complicit in the carceral logics of the mental health system in a dispersed neoliberal power structure.

Method

The findings presented here were unexpected findings from a broader research study which explored experiences of help-seeking for suicidal distress in rural and remote NSW emerging during analysis.

Semi-structured qualitative interviews were conducted with workers and volunteers in the mental health and/or social welfare sectors (six participants) and people who identified as carers (three). All participants were from a similar geographic area. Participants were recruited through advertising in newsletters, professional networks and contact with local gatekeepers.

This study did not exclude men from participating; however, all the participants who identified as carers also identified as women. Two provided care for children aged under 18, and one for her spouse. One carer support worker was interviewed, who reported on multiple other caring experiences as well as her own. The six workers interviewed came from a range of backgrounds including social workers, general practitioners, and volunteers.

The interviews were transcribed and analysed using reflexive thematic analysis (Braun & Clarke, 2019). The data were read closely and coded into themes which were reviewed using conceptual analysis. This included adopting a critical, gendered lens which focused on exploring constructs of gendered experiences. Particular attention was paid to the inconsistencies, incongruences and "missing" pieces of discursive logic to identify potential subjugated knowledges/resistances (Foucault, 1981).

Ethics approval for this study was provided by the University of Sydney Human Research Ethics Committee.

Limitations

The study sample was small, meaning the findings do not represent all caring experiences. This is likely due to the challenge of recruiting participants from small towns and communities.

Further, all the participants identified as white. This is problematic when considering caring. Intersectional feminists have argued the majority of low and underpaid workers who provide care are Black, Asian, First Nations and Latinx, it is largely the white who have the privilege of choosing an interdependent caring position (Sahraoui, 2019). There is evidence of this in Australia. For example, the history of forced labour for First Nations peoples, including caring roles for First Nations women, and current over-representation of women from Central and South-East Asia in the aged care workforce (Australian Institute of Health and Welfare, 2023). Further research is needed to examine intersectional experiences of caring and the mental health system.

Findings

Three main themes emerged. Firstly, engagement with mainstream mental health systems redefined relationships to support carceral logics. Secondly, women themselves became objects of disciplinary gaze requiring regulation or control. Finally, some women engaged in resistances. Radically reforming relationships with their loved ones outside of the regulation of the mental health system.

Redefining relationships to support carceral logics

When women in this study discussed what they wanted for their loved one, it was for them to be safe and well, with an emphasis on wanting to maintain a loving relationship.

In contrast, service providers positioned carers as extensions of the care system. Carers were part of the risk-mitigation strategy, primarily fulfilling a panoptic role—providing surveillance and information which should be fed back to the treatment team. The degree and nature of the involvement of carers featured in the considerations of workers about the degree of restrictive measures used in managing suicidal distress. Workers associated the presence of carers with increased safety, reducing the likelihood of involuntary treatment.

> Worker 4: … and it's very important who someone's living with. So, are they alone? Do they have any supports? … because you want to do some safety planning with the person, but sometimes people just—there's nothing you can put in that plan, because there's no one in their life, there's no one they can feel they can contact.
>
> Worker 1: And yeah, between the parents and the police, they made that call that they could guarantee the safety [of the service user] overnight.

NSW Mental Health legislation empowers police to involuntarily transport people for assessment if police determine the person is at significant risk of harm to themselves or others. Here, a worker describes why a person was not admitted to hospital. The worker creates a parallel between parents and police. Carers are positioned by the police and health system as delimiting their loved one's suicidal actions, outsourcing the carceral role of the hospital. Carers also remarked on how their relationships with their children typically changed after they encountered mainstream mental health services. They discussed "boundaries" which they had to put around their loved ones' behaviour.

> Carer support worker: … it's just a role they find easy to slip into sort of, um, yeah. So and they just … think, oh, well, I'll go back to when, you know, they were little. And yeah, you sort of were managing more of their life. But of course, you know, that's unrealistic. But I think that's just their protective mechanism. And for trying to make sense of what they can do to help.

Carers found themselves being (re) positioned as extensions of the care system, including the carceral logics of surveillance and control.

In addition, carers mentioned being expected to have a high level of knowledge about diagnosis and treatments. This included understanding how to manage medications and support engagement in therapy. One carer reported being asked to care for her son at home during a medication transition which resulted in police being called.

> Carer 1: Yeah, and I think one of the things I've really found with [NAME] is, there's no case management of it. Yeah. So we're leaving it up to an individual. To a kid because not everyone has a family, to kid or an adolescent, for them to manage their own pathway through getting support. Or we're leaving it up to a mum or dad or an auntie or carer.

This again demonstrates the expectation that carers will perform functions equivalent to a specialist mental health service.

Disciplining female carers

At the same time as it was presumed carers would be able to provide ongoing and, at times, highly skilled support for their loved ones, carers were problematised. Workers discussed concerns that carers may be a cause of distress, particularly amongst young

people. Carers themselves reported being assessed by professionals based on their emotional expression.

> Carer 1: … we then got a call to say sorry we don't have a bed anymore. And we were like, "we don't understand, how do we not have a bed?" What we've since learned … That a mother in [town name] hospital was so overwhelmed and emotional that her child got my child's bed because they thought she won't cope with taking the child home.

In this example, the two mothers' emotions were being assessed resulting in different degrees of carceral response. The mother who was considered non-emotive was perceived as capable of performing the functions of surveillance and adherence to the "treatment" regime. Her child was "safe" enough; whereas the highly emotional mother was deemed "unable" to provide the necessary supports, which merited state intervention.

Women who support loved ones may be disciplined for attempting alternative supports. A carer support worker discussed receiving multiple referrals from Child and Adolescent Mental Health workers because parents were acting in opposition to the psychologists' advice.

> Carer support worker: I think that they come out of that health system, often having poor understanding of the relationship between the child and the psychologist. Poor understanding of what the psychologists aim is, or how, what sort of therapy they're applying.

Most of the carers in this research discussed becoming therapeutised themselves, often having engaged in their own counselling or therapy. Their own distress, often directly resulting from their interaction with the mainstream mental health system, was pathologised. Thus, caregiving women became objects of the disciplinary gaze.

Resistance

Carers engaged in multiple types of resistances to the carceral logics of the mental health system. This included self-advocacy and, at times, choosing to oppose the recommendations of psychiatric professionals. Carers engaged in self-guided learning, online groups, research projects and, in some cases, even changed careers.

Significantly, women who had been in caring roles for longer discussed intentionally moving away from the panoptic role to one which encompassed a radical choice for their loved one and rejected the carceral response.

> Carer: Suicide prevention … I hate that word. Because I didn't, I wasn't able to prevent it from happening. It's, it's like you should be able to prevent every suicide, which, you know, lots of people that I've spoken to … their children have been in therapy, their children have been in institutions ... and they still take their own life. So you know, what more can you do then? Have them engaging in the services and on medication and the outcome's still the same.
> Carer worker: ... but when they're older; when they're older. … And they're sort of and they've had a bit more experience with services. … they've reached that point where they know they really don't have any control over the person's, um, what that person does with their life. And they may choose death.

Carers intentionally stepped away from a carceral role to one of respect. They resisted the carceral narrative, even to the point of acknowledging that their loved one may choose to end their own life. This is radically different from the logics of the mainstream mental health system in which the potential of harm to oneself (or others) is controlled through involuntary and unwanted treatment. Rather, this position represents a form of radical acceptance within the relationship far more closely aligned with feminist ethics. At the same time, by

positioning their relationship in this way, women also enable their loved ones' agency which the mental health system denies, thus challenging the disabling that occurs within the mental health system.

Discussion

This research contributes to understanding the embodied experience of the harms felt by women who support loved ones through carceral logics within the mental health system (Alexander, 2021). This study found that carer's choices are significantly restricted when interacting with the mainstream mental health system. There is an expectation that carers will perform a carceral role by providing surveillance and restriction in the home, and failure to do so results in the carer herself becoming the object of disciplinary power. Workers actively constructed carers as either an extension of the apparatus of the state, or as problems which need to be "treated".

The above is reflective of the carceral logics of the caring role. Carers are positioned as responsible for regulating the emotions within the domestic sphere, which is seen as requiring less expertise and value than professional workers. Carers must manage their loved one's "messy" emotions and problems associated with suicidal distress, ensuring that emotional "detritus" remains contained (Hughes et al., 2005). This demarcation of distress further others and (dis)ables people experiencing distress by excluding them from participation outside of the domestic sphere.

Despite this, the women in this study actively engaged in a range of resistances. Significantly for some, there was a change—a rejection of the carceral role to one of respect. The focus was not on treatment or removing the person's desires for death. Rather, with time and the opportunity for reflection, some women adopted a position of respect for their loved one, including a right to die, and maintained deep relational connectivity. This displaced suicidality as the object of gaze, and instead positioned the integrity of the relationship between two people as the central focus. This position represents a radical step away from carceral power. This echoes Gruber's (2020) call to engage in new feminist imaginations to find alternatives to carceral logics. It represents a more feminist notion of ethics which positions mutuality in relationship as the centre of justice.

Conclusion

Social workers have an ethical obligation to oppose injustice and promote social flourishing. The findings of this study indicate several recommendations. Firstly, the importance of social workers in the mental health system developing critical self-awareness of their engagement in discourses that responsibilise and discipline carers. Secondly, that social workers embrace creative alternatives based on feminist knowledges outside of carceral measures. Thirdly, that social workers engage in actions which advocate opposing involuntary treatment and carceral logics throughout the mental health system, including in legislation.

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